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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5226

CERTIFICATE OF DEATH

05215

Reg. Dist. No. 203

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH COUNTY <u>KENT</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROCK HALL</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>KENT</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROCK HALL</u> STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ARLINDA</u> <u>BECK</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>MAY</u> <u>24</u> <u>1956</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>Col.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>JAN. 1 - 1878</u> |
| 9. AGE last birthday <u>78</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Hopkins</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS <u>Marcellus Beck - Chesterton</u> | | | |
| 18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>444</u> IMMEDIATE CAUSE (A) <u>Semiditox</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 18</u> , 19 <u>56</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>E. Keister</u> | | ADDRESS (Street, city, town, state) <u>Rock Hall</u> | |
| DATE <u>May 26</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>MAY 26</u> | | DATE THEREOF | |
| NAME OF CEMETERY OR CREMATORY <u>Codesville</u> | | LOCATION (City, town, or county) (State) <u>Codesville Ind</u> | |
| 24. REC'D BY REGISTRAR <u>May 26</u> | | REGISTRAR'S SIGNATURE <u>S. Elwood Burgess</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u> | | ADDRESS <u>Church Hill, Md.</u> | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF COURT

22. SIGNATURE OF STATE

23. SIGNATURE OF COUNTY

24. SIGNATURE OF CITY

25. SIGNATURE OF TOWN

26. SIGNATURE OF VILLAGE

27. SIGNATURE OF POST OFFICE

28. SIGNATURE OF SCHOOL

29. SIGNATURE OF CHURCH

30. SIGNATURE OF SYNAGOGUE

31. SIGNATURE OF MOSQUE

32. SIGNATURE OF TEMPLE

33. SIGNATURE OF MONASTERY

34. SIGNATURE OF CONVENT

35. SIGNATURE OF NUNNERY

36. SIGNATURE OF HERMITAGE

37. SIGNATURE OF CLOISTER

38. SIGNATURE OF CHAPEL

39. SIGNATURE OF ALTAR

40. SIGNATURE OF PULPIT

41. SIGNATURE OF TABERNACLE

42. SIGNATURE OF SACRISTY

43. SIGNATURE OF CHANCEL

44. SIGNATURE OF AISLE

45. SIGNATURE OF NAVE

46. SIGNATURE OF TRANSEPT

47. SIGNATURE OF CHANCEL

48. SIGNATURE OF AISLE

49. SIGNATURE OF NAVE

50. SIGNATURE OF TRANSEPT

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259. SIGN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5218

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05216

Reg. Dist. No. 202

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Md.</u> 37 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00</u> | | | | d. STREET ADDRESS <u>355 Calvert St</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>GREGORY</u> Middle <u>LEE</u> Last <u>BESSICKS</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan 30, 1956</u> | |
| 9. AGE (In years last birthday) <u>7</u> yrs. | | IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>1</u> Min. <u>0</u> | | IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Honston O. Bessicks</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marian J. Frisby</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Marian J. Frisby Chestertown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown</u> 795.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Found dead in crib about 8:30 am</u> DUE TO (c) <u>Was apparently well right before</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>May 24, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Janes Cemetery</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Willis Wells</u> ADDRESS <u>Chestertown Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>May 24-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u> | |

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

5/22/56

TO DULY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2072312344

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 25 1956

RECEIVED

5219

CERTIFICATE OF DEATH

Reg. Dist. No.

201

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kentland Home Care</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Clendaniel</u> Last <u>Clendaniel</u> | | 4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 20 1874</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPAIR TRUCK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>STATE ROADS</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOHN CLENDANIEL</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY HIGMAN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-07-50034</u> | |
| 17. INFORMANT <u>ELIZABETH CLENDANIEL</u> | | Address <u>KENNEDYVILLE, MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Hypertension</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Years</u> <u>Years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, myocardial infarction, coronary artery disease, long standing</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT, WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>4-25</u> , 19 <u>56</u> , to <u>5-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-19</u> , 19 <u>56</u> , and that death occurred at <u>11:30</u> p.m., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. | | ADDRESS (Street, city or town, state) <u>Chesapeake</u> DATE SIGNED <u>5-19-56</u> | |
| PHYSICIAN'S NAME (Type) <u>A.C. Dick</u> | | <u>Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>5-22-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>CHESTERTOWN MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>STILL POND, MD</u> | | 24a. REC'D BY REGISTRAR DATE <u>5/22/56</u> 24b. REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u> | |

MEDICAL CERTIFICATION

TO HOUSING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

BUREAU V. S.

MAY 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05218

Reg. Dist. No. 202

5220

| | | | | | | | |
|---|---------------------------|--|-------------------------------------|--|-----------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Jefferson</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | | | c. LENGTH OF STAY IN 1b <u>2 Da.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Annes Hosp.</u> | | | | d. STREET ADDRESS <u>Main Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Margaret Estelle Cotta</u> | | | | 4. DATE OF DEATH <u>May 22</u> 19 <u>56</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 6 1903</u> | 9. AGE (In years last birthday) <u>52</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>--</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Daniel Bagent</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u> | | 17. INFORMANT <u>Hospital Records</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>593x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephritis</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5-20-56</u> <u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>5-20</u> , 19 <u>56</u> , to <u>5-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-22</u> , 19 <u>56</u> , and that death occurred at <u>10:10 M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. | | | | DATE SIGNED <u>Chestertown, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A.C. Dick</u> | | | | ADDRESS (Street, city or town, state) <u>Chestertown, Maryland.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/26/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harpers Ferry W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>May 25 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5221

CERTIFICATE OF DEATH

05219

Reg. Dist. No.

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Kent</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesertown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne's Hosp.</u> | | d. STREET ADDRESS <u>Rock Hall</u> | |
| 3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Faithful</u> Middle <u>Faithful</u> Last | | 4. DATE OF DEATH <u>May</u> Month <u>19</u> Day <u>19</u> Year <u>56</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-17-1885</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George Faithful</u> | | 14. MOTHER'S MAIDEN NAME <u>Rodisa Sparks</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Ms. Wilmer Hall - Centerville Ind</u> | |
| 17. INFORMANT <u>Ms. Wilmer Hall - Centerville Ind</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tobacco pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 15, 1956</u> , to <u>May 19, 1956</u> , that I last saw the deceased alive on <u>May 18, 1956</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Willard Smith</u> M.D. | | ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>5/19/56</u> | |
| PHYSICIAN'S NAME (Type) <u>WILLARD SMITH, MD</u> | | | |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify) | 22b. DATE THEREOF <u>May 21</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Ind.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Ind.</u> | | 24a. REC'D BY REGISTRAR DATE <u>5/23/56</u> | 24b. REGISTRAR'S SIGNATURE <u>Clara Barnes</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5227

CERTIFICATE OF DEATH

Reg. Dist. No. 200

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>KENT</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MILLINGTON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MILLINGTON</u> | | | |
| c. LENGTH OF STAY IN 1b <u>8 yrs.</u> | | | | d. STREET ADDRESS <u>RURAL MILLINGTON</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>A.</u> Last <u>FUCHS</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1956</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>AUG. 31, 1886</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>JOHANNES FUCHS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARIE PFUFFEWROTH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>214-12-6000</u> | | 17. INFORMANT <u>MRS. LENA FUCHS</u> Address <u>MILLINGTON, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Glomerulonephritis</u> DUE TO (c) <u>Fibrosis of the lungs</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>4 months</u> <u>for years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>May be cancer of the esophagus</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Jan 19</u> , 19 <u>56</u> , to <u>May 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>56</u> , and that death occurred at <u>9.20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Millington, MD.</u> DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE <u>Geza Koralewski</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>MAY 16, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>CRUMPTON, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Millington, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5/15/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Edward Fellows</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

5222

CERTIFICATE OF DEATH

Reg. Dist. No. 202

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | | | c. LENGTH OF STAY IN 1b <u>2 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Annes Hosp.</u> | | | | e. STREET ADDRESS <u>222 Cannon Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM RICHARD GOODMAN</u> | | | | 4. DATE OF DEATH Month Day Year <u>May 19 19 56</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 26, 1874</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery sexton</u> | | 11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jesse Goodman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Pearce</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-20-7984</u> | | 17. INFORMANT Address <u>222 Cannon St.</u> <u>Mrs. Sadie R. Goodman, Chestertown, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary thrombosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute cholecystitis with cholelithiasis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>Several years.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>5-17-</u> <u>1956</u> , to <u>5-19</u> <u>1956</u> , that I last saw the deceased alive on <u>5-19</u> <u>1956</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>5/19/56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>A. C. Dick</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>A. C. Dick</u> <u>Chestertown, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 22/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Worton Kent Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>May 22-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

JAN 24 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05222

5228

CERTIFICATE OF DEATH

Reg. Dist. No. 203

| | | | | | | | |
|--|-------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>KENT</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>KENT</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ROCK HALL</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u> | | TOWN <u>HALL</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) <u>ROLAND</u> (Middle) <u>LARRIMORE</u> (Last) | | | | 4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>27</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>MAY 10 - 1869</u> | 9. AGE last birthday <u>87</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Wm. Harrimore</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harrison</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Mrs. Barbara Harrimore</u> <u>Rock Hall, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 444X IMMEDIATE CAUSE (A) <u>Senility</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>May 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5715</u> , 19 <u>56</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>D. Kester</u> | | | | ADDRESS (Street, city, town, state) <u>Rock Hall</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF <u>MAY 29</u> | | NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u> | | LOCATION (City, town, or county) (State) <u>Rock Hall Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>S. Elwood Bangs</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u> | | ADDRESS <u>Church Hill, Md.</u> | |
| DATE <u>May 29/56</u> | | | | | | | |

15553

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1. NAME OF DECEASED

MASSACHUSETTS
BUREAU OF VITAL RECORDS

2. DATE OF DEATH

3. PLACE OF DEATH
4. CITY
5. STATE
6. COUNTY

7. TIME OF DEATH
8. CAUSE OF DEATH

9. MEDICAL CERTIFICATION
10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR
12. DATE OF REGISTRATION

13. SIGNATURE OF DECEASED
14. DATE OF DEATH

15. SIGNATURE OF WITNESSES
16. DATE OF DEATH

17. SIGNATURE OF DECEASED
18. DATE OF DEATH

19. SIGNATURE OF WITNESSES
20. DATE OF DEATH

21. SIGNATURE OF DECEASED
22. DATE OF DEATH

23. SIGNATURE OF WITNESSES
24. DATE OF DEATH

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
RECEIVED
JUN 4 1956

BUREAU V. R.

JUN 4 1956

RECEIVED

5223

CERTIFICATE OF DEATH

Reg. Dist. No. 202

| | | | | | | | |
|--|------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37</u> <u>Chestertown</u> | | | | c. LENGTH OF STAY IN 1b <u>Life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>516 Cannon St.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>LEAVERTON</u> Last <u>LEGG</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1956</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 2, 1904</u> | 9. AGE (In years last birthday) <u>51</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1</u> <u>Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Automobiles</u> | | 11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry H. Legg</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Estelle Ada Sparks</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>216-09-3965</u> | | 17. INFORMANT <u>Mrs. Marie B. Legg, Chestertown, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>51 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>5-29</u> , 19 <u>56</u> to <u>5-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-29</u> , 19 <u>56</u> , and that death occurred at <u>5:15 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE <u>A. C. Dick</u> | | | | M.D. <u>5-30-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A. C. Dick</u> | | | | <u>Chestertown, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 1 / 56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>June 2-1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. S.

JUN 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5229
CERTIFICATE OF DEATH

05224

Reg. Dist. No. 202

| | | | | | | | |
|---|---------------------------------|--|--------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | | | c. LENGTH OF STAY IN life <u>life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u> | | | | d. STREET ADDRESS <u>R.F.D. (Quaker Neck)</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Thompson</u> Middle <u>Lewis</u> Last <u>Lewis</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1956</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 3, 1885</u> | 9. AGE (In years last birthday) <u>70</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Laborer)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer (Various)</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Lewis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hester</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>220-I6-9660</u> | | 17. INFORMANT <u>Charles Lewis</u> Address <u>Chestertown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>May 8, 1956</u> to <u>May 8, 1956</u> , that I last saw the deceased alive on <u>May 8, 1956</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>May 9, 1956</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Eugene Hester</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Eugene Hester - Rock Hall, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 12, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Pomona Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rural - Chestertown, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u> ADDRESS <u>Chestertown, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>May 11-1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Barnes</u> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF CALIFORNIA

ORE 18

Page 101

DATE OF DEATH

DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

BUREAU V. S.

MAY 14 1952

RECEIVED

5224

CERTIFICATE OF DEATH

Reg. Dist. No. 202

| | | | | | | | |
|---|-------------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piney Neck</u> | | | |
| c. LENGTH OF STAY IN 1b <u>3 da.</u> | | | | d. STREET ADDRESS <u>Rock Hall</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Annes Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNA</u> C Middle <u>LINDGREN</u> Last | | | | 4. DATE OF DEATH Month <u>May</u> 22 Day <u>22</u> Year <u>19 56</u> | | | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 7 1891</u> | | 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secty. Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Meter</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York City</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Carl Lindgren Larson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Johnson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>-----</u> | | 17. INFORMANT Address <u>224 Central Ave</u> <u>Mrs. Louis O. Potter, Norwich, Conn.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416x Coronary thrombosis</u> DUE TO (b) <u>Rheumatic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>50 years</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>May 21, 1956</u> , to <u>May 22, 1956</u> , that I last saw the deceased alive on <u>May 22, 1956</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Rock Hall, Md</u> DATE SIGNED <u>May 22, 56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. Willard F. Smith</u> | | | | <u>Rock Hall, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 24 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Marvin V. Williams, Chestertown, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>May 25-1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. E.

MAY 28 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

2-03

5230

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE | |
| Chesapeake Bay MARYLAND | | Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Near-Bay Shore Park | 11 days | Baltimore City 3v01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | d. STREET ADDRESS | |
| Remains Brought Ashore-Rock Hall | | 5714 Greenspring Ave. | |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | Month Year |
| GEORGE WILLIAM MARTIN | | May 6 1956 | 19 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH |
| Male | White | | Aug. 4, 1931 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| Construction | | Contracting | Maryland |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Louis Francis Martin Sr. | | Anna Winter | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| yes ✓ Korean | | 213-284500 | |
| | | 17. INFORMANT Address | |
| | | Virginia Martin Clothier, Rock Hall, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 850x DUE TO Subject fell overboard near Bay Shore Park at 6:30 p.m. 5/6/56. Was found floating in Chesapeake Bay at 4:15 p.m. on 5/17/56, two miles west of Rock Hall, Md. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| I did not attend deceased, but investigated case on 5/17/56 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| | | | |
| 20c. TIME OF INJURY Month, Day, Year | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| Hour 6:30 p.m. 5/6/56 19 | | While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | Chesapeake Bay Bay Shore Park Md. |
| 20f. (City or town) (County) (State) | | | |
| Bay Shore Park Md. | | | |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| Sub. Assistant Deputy Med. Examiner | | | |
| FLORENCE DERINGER JOYCE M.D. Worton, Kent, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY |
| Burial | | May, 19/56 | Druid Ridge Cemetery |
| | | | Pikesville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE |
| Marvin V. Williams, Chestertown, Md. | | DATE 5/18/56 | S. Shivers |

after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician or the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the funeral director may detach page 3 from the certificate and use it as the burial-transit permit. Then please remove carbon paper from the certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAY 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05227

Reg. Dist. No. 200

5231

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GOLT</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>KENT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GOLT</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>PERRY RILEY</u> | | 4. DATE OF DEATH Month Day Year <u>MAY 26 1956</u> | |
| 5. SEX <u>M.</u> 6. COLOR OR RACE <u>COLORED</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 2, 1878</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABOR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> 11. BIRTHPLACE (State or foreign country) <u>MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WILLIAM RILEY</u> 14. MOTHER'S MAIDEN NAME <u>ELLEN - UNKNOWN</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>ANNIE REESE</u> Address <u>KENNEDYVILLE MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Coronary Artery Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chor. Coronary-Renal disease</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>6 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No accident</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>— — 19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 19, 1956</u> , to <u>May 26, 1956</u> , that I last saw the deceased alive on <u>May 19, 1956</u> , and that death occurred on <u>May 26, 1956</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H. H. Hamilton</u> M.D. <u>Williamston Md.</u> | | DATE SIGNED <u>5/29/56</u> | |
| PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>MAY 30-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>DAVIS HILL CEM.</u> | 22d. LOCATION (City, town, or county) (State) <u>RURAL GALENA MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward H. H. H. Hamilton</u> ADDRESS <u>Williamston Md.</u> | | 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>9/1/56</u> | 24b. REGISTRAR'S SIGNATURE <u>E. J. D. H. H. H.</u> |

MAVING STATE DEPARTMENT OF HEALTH-BALTIMORE 18

JUN 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5225

CERTIFICATE OF DEATH

05228

Reg. Dist. No. 202

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY KENT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN | | | | c. LENGTH OF STAY IN 1b 4 mos. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S HOSP. | | | | d. STREET ADDRESS ROCK HALL. | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES N. WAGNER | | | | 4. DATE OF DEATH Month Day Year MAY 9 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 1, 1894 | 9. AGE (In years last birthday) 61 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILLIAM WAGNER | | | | 14. MOTHER'S MAIDEN NAME JOHANNA SCHWARTZ | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK. | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address HOSPITAL CHART. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X CARCINOMATOSIS, generalized DUE TO Carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 8 mos. DUE TO (c) 8 mos. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JAN 28, 1956 , to MAY 9, 1956 , that I last saw the deceased alive on MAY 9, 1956 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Arthur T. Keefe, Jr. | | M.D. CHESTERTOWN, Md | | MAY 9, 1956 | | | |
| PHYSICIAN'S NAME (Type) ARTHUR T. KEEFE, JR. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 12 | | 22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel | | 22d. LOCATION (City, town, or county) (State) Rock Hall Ind. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edgar H. Kane Church Hill, Md. | | | | 24a. REC'D BY REGISTRAR DATE May 14-56 | | 24b. REGISTRAR'S SIGNATURE Clara S. Barnes | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 15 1956

RECEIVED